Health Professions Quality Assurance Division
PO Box 47867
Olympia, WA 98504-7867

WASHINGTON STATE DENTAL LICENSURE
INFORMATION AND INSTRUCTION SHEET

Introduction:

These instructions are designed to assist you in the application process for dental licensure in Washington State. Please read and follow them thoroughly. A check list format has been used to assist you in requesting documentation and to ensure you meet all application requirements.

Washington State currently has two methods by which to obtain dental licensure. References to the appropriate rules and regulations are indicated and should be referred to as you complete the application process.

1. Licensure Via Examination Standard: (Western Regional Examining Board (WREB) (Refer to WAC 246-817-110 and 246-817-120)

The Dental Quality Assurance Commission voted to join the Western Regional Examining Board in September 1994. Upon successful completion of the WREB examination, dentists are eligible to apply for licensure in any of the WREB member states. (While the exam requirement is the same for all member states, you must contact each member state directly to receive state-specific licensure/application information.) Washington state will accept the results of the WREB examination for up to five years immediately proceding application

WREB member states currently include Alaska, Arizona, Idaho, Montana, New Mexico, Utah, Oregon, Oklahoma, Texas and Washington.

NOTE: Foreign trained dentists must also meet the specific education requirements for Washington State. (Refer to WAC 246-817-160).

2. Licensure Without Examination Program (LWOE): (Refer to WAC 246-817-130 through 246-817-140)

This program was implemented in 1990 and allows dentists already licensed by equivalent examination in other states to apply into Washington state without repeating a clinical examination. An established practice history of at least five years out of the seven years preceding application is also required. The Commission conducts annual evaluations of all other state/regional exam criteria to determine equivalency for this program. As we cannot mandate the licensure requirements for other states, this program does not allow an automatic reciprocity arrangement with other states.

Please anticipate a minimum of 4 - 8 weeks for complete application processing. Documentation from other states, and background checks typically take several weeks for processing once requested.

Once the application is received, an acknowledgment letter will be sent after initial application review, advising of any remaining deficiencies.

☐ **Application Form**

Application must be completed in full, notarized and submitted with the required fee to the address indicated below. The chronology portion of the application requires documentation of all time periods (month/year) from dental school graduation to present, whether related to dental practice or not.

B. ☐ **Photograph (signed and dated)**

Submit a current 2" X 2" photograph, signed and dated, and affixed to the back page of the application.

C. ☐ **Application Fee ($325.00 for exam, $700.00 without exam)**

Must be paid in U.S. funds, by personal check or money order and submitted with the application form. Applications will not be processed without appropriate fee. (See 246-817-990 for complete fee schedule.) Make checks payable to "Department of Health".

D. ☐ **National Board Scores (Part I and II)**

The original scorecard or a notarized copy of the scores must be provided. To obtain documentation contact: Joint Commission on National Dental Examinations, 211 East Chicago Avenue, Suite 1846, Chicago, Illinois 60611. Telephone Number 1-800-621-8099

E. ☐ **Transcript (with degree posted)**

Transcripts must be posted with dental degree from an accredited dental school, must include a date of graduation and must be sent to us directly from dental school. Non-posted transcripts or student copies are not acceptable. Foreign trained dentists must meet the additional education requirements outlined in WAC 246-817-160.

F. ☐ **License Verifications**

License verifications must be requested by the applicant and submitted directly from every state in which applicant is currently licensed or has held licensure. (Note: Many states charge a certification processing fee, please contact them prior to request to prevent delays in processing.)

G. ☐ **Malpractice Clearance**

Applicant must have malpractice carrier submit a letter verifying dates of coverage and any claims history. In the event of a claims history, appropriate legal documentation must also be submitted. (If coverage is provided via an umbrella policy through a school, or it you are practicing in the military, please indicate in writing.)

H. ☐ **7 Hours of AIDS Education**

Healthcare Practitioners entering Washington state are required to document aids education and training. (See WAC 246-817-201 for specific course content requirements.) If you need an AIDS training course, you can obtain a videotape/exam packet that meets the requirements by contacting: Mr. Randy Newquist, University of Washington, Department of Continuing Dental Education - Telephone (206) 543-5448

I. ☐ **Disclosure of Information Authorization**

To be completed by persons currently licensed in other jurisdictions. This authorization allows us to conduct background checks from the listed entities.

J. ☐ **Military/Commanding Officer Letter**

If applicant is on active duty in the military, a letter must be submitted from the commanding officer outlining duties, length of service and whether any adverse actions have been reported or taken.

K. ☐ **Jurisprudence Examination**

The jurisprudence examination is the final phase of the application process. Once the application, fee, and all documentation is received and reviewed and the application is determined complete, the jurisprudence examination will be mailed to you. This examination is multiple choice, open book and designed to familiarize you with the contents of the Washington State Dental Law. A return envelope will be provided or the completed answer sheet may be faxed to this office.

L. ☐ **Western Regional Examining Board (WREB) / Central Regionl Dental Testing Service (CRDTS) Certificate**

A notarized copy of the WREB or CRDTS certificate must be submitted by the applicant. This document verifies passage of the examination, date and location taken, and confirms that no outstanding requirements are owed to WREB. WREB examination results will be accepted for up to five years preceding application to Washington state. Applications for the examination should be requested directly from WREB at (602) 944-3315 or CRDTS at (785) 273-0380.

☐ **Proof of Equivalent Examination**

The LWOE program requires that the applicant have taken an equivalent examination in another jurisdiction with standards equivalent to those of this state. A listing of equivalent states is provided with this packet. **If your state of licensure is not on the list, please refer to WAC 246-817-140 (2) to determine if you qualify for this program on an individual basis.** If so, this will require that you request documentation from the state or regional exam entity to demonstrate that you successfully completed an equivalent examination. The regional exam entities (i.e. CRDTS, NERB) are familiar with this requirement and can provide a letter outlining the exam criteria of any given examination.

N. ☐ **Practice Location Form**

This form must be completed in full. You must attest to a minimum practice time of 20 hours per week, and document a practice history of at least five years of the seven years immediately preceding application. Locations of practice, malpractice carrier, and federal and state tax ID numbers must also be provided as means to verify the required practice history. (If in the military, please indicate. We are aware that malpractice insurance, federal or state ID numbers are not necessary in that setting.)

IMPORTANT INFORMATION

All documentation must be sent to this office directly from the original sources. Failure to have documentation submitted from original sources will result in delay to the processing of your application.

Affirmative Responses to Personal Data Questions

If you answer "yes" to any of the personal data questions, for any reason, you must submit additional supporting documentation for that question as indicated on the application. The Commission will not consider an application that is deficient in any way. This documentation should include:

1. **Written letter** of explanation from you outlining the original complaint, persons involved, your summary, and any resolution reached either personally, through the courts, or through your malpractice company.

2. **Certified copies** of initial complaints, Findings, Conclusions and Judgments. In the event of a malpractice suit, these documents are filed in a court of law.

3. **Certified copies** of any settlement documents.

As the involved practitioner you may have this documentation in your personal files. If you do not, it is your responsibility to obtain the information directly from your malpractice carrier, your attorney, or the court in which the complaint was filed and/or settled.

All information and supporting documentation must be received within 180 days of the filing of the initial application and fee. The Commission will only review complete applications. The Commission will review completed applications at regularly scheduled meetings, (usually at 6 week intervals) or as determined necessary.

Temporary Practice Permits: Dentists currently licensed in other states may be eligible to obtain a temporary practice permit upon written request. Please refer to WAC's 246-817-185 and 246-817-186 for specific eligibility criteria. Most often we are able to process a completed application and issue a full license in the same timeframe it would take to issue a temporary permit.

In the event an application is denied, the applicant will have an opportunity to have a hearing before the commission.

All application and licensure information is subject to public inspection and copying under Washington State Public Disclosure law. Applicants and licensees may submit written request to have residential address and residential telephone number be exempt from public disclosure. An alternative personal or business address and telephone number must be provided.

Washington state law and Department of Health Policy prohibit employees from receiving gifts, gratuities and/or favors. Any offer of private benefit to any employee that is intended to influence a public decision is bribery and violates Federal and State law.

To Expedite Processing of your Application:

Send application and fee (payable to "Department of Health") to:

Dental Quality Assurance Commission
Department of Health
P O Box 1099
1300 Quince Street SE
Olympia, WA 98507-1099

NOTE: Express Mail requires use of street address for delivery.

Send all other supporting documentation to:

Dental Quality Assurance Commission
P O Box 47867
Olympia, WA 98504-7867

Telephone: (360) 236-4861
Fax: (360) 664-9077
Office Hours: 8:00 am to 4:30 pm daily

If you plan on coming to the office, please call and schedule an appointment.

NOTE: Express Mail requires use of street address for delivery

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
CERTIFICATION #:	DATE ISSUED

CERT #

LICENSE TO PRACTICE FOR DENTISTRY

Please Type or Print Clearly - Follow carefully all instructions in the general instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. All applications must be accompanied by applicable fee. Make remittance payable to the Department of Health.

1. DEMOGRAPHIC INFORMATION

APPLICANT'S NAME	LAST	FIRST	MIDDLE INITIAL

MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING NORMAL BUSINESS HOURS.)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (REQUIRED FOR IDENTIFICATION PURPOSES ONLY.)
( )	( )	

GENDER	BIRTHDATE	PLACE OF BIRTH	MAIDEN NAME
☐ Female ☐ Male			
HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR
DENTAL SCHOOL		YEAR GRADUATED	D.E.A. # (IF APPLICABLE)

2. PREVIOUS LICENSURE

List all states where licenses are or were held. (Previous credential to include license, certification or registration.) Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

STATE OR OTHER	PROFESSION	CERTIFICATE		PERMANENT OR TEMPORARY	LICENSE RECEIVED BY		CURRENTLY IN FORCE
		YR ISSUED	NUMBER		EXAMINATION	OTHER	

3. AIDS EDUCATION AND TRAINING ATTESTATION

☐ School Curriculum ☐ Continuing Education

I certify I have completed the minimum of seven hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infectious control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and the psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my certification may be denied, or if issued, suspended or revoked.

Applicant's Initials _____ Date _____

4. PERSONAL DATA

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ❒ ❒

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ❒ ❒

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ❒ ❒

4. Are you currently engaged in the illegal use of controlled substances? ❒ ❒

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

   Note: If you must answer "yes" to any of the remaining questions, provide an explanation and copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ❒ ❒

   b. a charge of a sex offense? ❒ ❒

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ❒ ❒

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ❒ ❒

   b. committed any act involving moral turpitude, dishonesty or corruption? ❒ ❒

   c. violated any state or federal law or rule regulating the practice of a health care professional? ❒ ❒

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ❒ ❒

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ❒ ❒

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ❒ ❒

5. PROFESSIONAL TRAINING AND EXPERIENCE

List in chronological order all professional education and experience including college or university (pre-dental program), technical or professional school and practice pertaining to the profession for which you are making application. Include all periods of time from the date of graduation from dental school to present whether or not engaged in activities related to dentistry. You do not have to list continuing education courses.

NAME AND LOCATION OF INSTITUTION, PLACE OF PRACTICE OR OTHER	DATES		DEGREE/CERTIFICATE AND DATE RECEIVED, NATURE OF EXPERIENCE OR SPECIALITY
	FROM (MO/YR)	TO (MO/YR)	

6. APPLICANT'S ATTESTATION

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby agree that such act shall constitute cause for the denial, suspension or revocation of my certification to practice in the State of Washington.

Signature of Applicant_____ Date _____

Subscribed and sworn to before me this day of _____ , 20____.

Notary in and for the State of _____

State Seal

Residing at _____

Signature of Notary _____

My Commission Expires _____

Attach Current Photograph Here. Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** BE:
1. Original, not a photocopy
2. No larger than 2" x 2"
3. Taken within one year of application
4. Close up, front view - not profile
5. Instant Polaroid Photographs **not** acceptable

Official Use Only

Washington State Records Center

Health Professions Quality Assurance Division
PO Box 47867
Olympia, WA 98504-7867

LICENSE CERTIFICATION FROM DENTAL EXAMINERS BOARD SECRETARY FOR THE STATE IN WHICH APPLICANT NOW LICENSED

I, _____ , Secretary of _____
(OFFICIAL NAME OF BOARD)

hereby certify that _____ was granted State Certification Number _____

to practice _____ in the State of _____

on the _____ day of _____ , 20 _____ on the basis of successfully passing the required examination.

Status of License: ☐ Current Expiration Date _____

☐ Expired Date _____

Type of License Issued: (Full, Limited or Conditional, if so explain.) _____

_____

_____

Legal/Disciplinary Action, if any: ☐ Yes ☐ No If **Yes**, explain: _____

_____

_____

_____

_____

_____

_____

I further certify that the preliminary and professional education of this applicant was verified by this Commission prior to the examination of the applicant.

Acting in behalf of the _____
(OFFICIAL NAME OF BOARD)

I hereby certify to the reputability of _____
as it appears on record in this office, and recommend him/her to the Dental Quality Assurance Commission of Washington as a fit and proper person to receive a license.

Secretary's Signature _____ Date Certification Prepared _____

SEAL

Return to: Department of Health
Dental Quality Assurance Commission
P O Box 47867
Olympia, WA 98504-7867

Health Professions Quality Assurance Division
PO Box 47867
Olympia, WA 98504-7867

LOCATION OF PRACTICE

NOTE: If for less than 5 years at this location, attach an additional sheet of paper, listing other practice locations.

I, _____ , certify that I am in the practice of clinical dentistry at the following location: _____

_____

_____

From _____ through _____
MONTH AND YEAR MONTH AND YEAR

I further certify that I have practiced dentistry, as defined in RCW 18.32.020, for at least a minimum of twenty hours per week.

Applicant's Signature _____ Date _____

Malpractice Insurance Carrier Information

Name _____ Telephone ( ) _____

Address _____

From _____ through _____

Name _____ Telephone ( ) _____

Address _____

From _____ through _____

Tax Numbers:

Federal No. _____ State No. _____

Health Professions Quality Assurance Division
PO Box 47867
Olympia, WA 98504-7867

AUTHORIZATION FOR INFORMATION DISCLOSURE

I am applying for a license to practice dentistry in the state of Washington and need documentation from your organization sent to the Department of Health, Dental Quality Assurance Commission to support this application

I, _____ , hereby authorize the following entities to release any pertinent information, derogatory or not, to the Department of Health, Dental Quality Assurance Commission:

- ☐ Drug Enforcement Administration (DEA)
- ☐ American Association of Dental Examiners
- ☐ National Practitioner Data Bank

Applicant's Signature _____ Date _____

Applicant: Please complete the form, sign, date and return to:

Department of Health
Dental Quality Assurance Commission
P O Box 47867
Olympia, WA 98504-7867